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Non-OST Route Transition Interventions among Injecting Drug Users in Kabul, Afghanistan: A Qualitative Feasibility Assessment Based on Institutional Stakeholders' Views

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Non-OST Route Transition Interventions among Injecting Drug Users in
Kabul, Afghanistan: A Qualitative Feasibility Assessment Based on
Institutional Stakeholders' Views

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B.A., Mississippi College, 1999

A Thesis
Submitted in Partial Fulfillment of the Requirements for the Degree of
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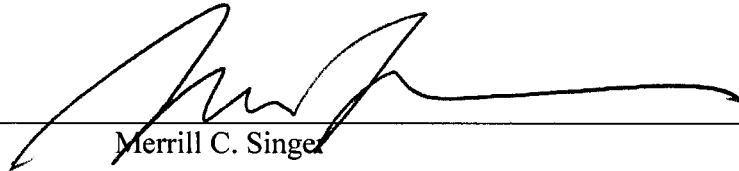
Master of Arts Thesis

Non-OST Route Transition Interventions among Injecting Drug Users in Kabul, Afghanistan: A Qualitative Feasibility Assessment Based on Institutional Stakeholders' Views

Presented by

William P. Tootle Jr.

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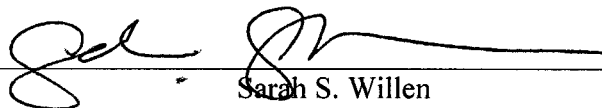
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2015

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Table of Contents

INTRODUCTION	1
METHODS	8
Participant Eligibility	8
Study Design and Measures	9
Data Collection	10
Data Analysis	10
THEMES	12
I. <u>Barriers</u> to Harm Reduction, RTI, and Treatment	12
Cultural Views on Drug Use	12
Stigma surrounding drug use	12
Dominance of abstinence-based approaches to drug use	14
Segregation of drug users from general population	15
Collective harm related to individuals' drug use	17
Knowledge and Opposition	18
Lack of knowledge about harm reduction and the harms of drug use	18
Community opposition to harm reduction and RTI	19
Police opposition to harm reduction/RTI and harassment of drug users	20
Intimidation or interference from drug traffickers	22
Institutional Challenges	24
Inter-agency cooperation and coordination	24
Organizational capacity	24
Funding	24
Professional training	25
Physical and Economic Risk Environment	25
Poverty	25
No sanctioned space for drug use	25
Lack of security	27
Route of Drug Administration	28
Drivers of injecting	28
Difficulty of the smoking technique	29
II. <u>Benefits</u> of RTI	29
Facilitates treatment	30
Improves social standing of IDUs	31
Incentivizes smoking over injecting	31
CONCLUSION	32
REFERENCES	37

ABSTRACT

An HIV epidemic threatens injecting drug users in Kabul, Afghanistan. Although opioid substitution therapy (OST) has been proven to reduce the spread of HIV and decrease injecting drug use in many parts of the world, including on a small scale in Afghanistan, political obstacles suggest that at this time it may not be a viable intervention there. In this thesis, therefore, I assess the feasibility of implementing an alternative to OST as an HIV-prevention strategy, namely, a non-OST route-transition intervention (RTI) designed to encourage and enable opiate users to switch from injecting to smoking (also called chasing). Based on semi-structured interviews and a focus-group discussion with drug-related institutional stakeholders in Kabul—including harm reduction professionals, treatment providers, public health officials, and police officers—I describe the perceived obstacles to, as well as facilitators and benefits of, harm reduction in general and RTI in particular. Most participants supported the RTI concept and believed that it would be feasible to implement such a program provided that doing so included educating communities and stakeholders about harm reduction and the harms of drug use, building cooperative alliances with them, and involving them in the planning process. Many also stressed the importance of incorporating a sanctioned place for opiate smoking into an RTI program. RTI appears to be a promising component of efforts to address the emerging concentrated HIV epidemic in Kabul and prevent its further spread, but it is not free of significant challenges. I discuss these and suggest potential ways of overcoming some of them.

INTRODUCTION

An explosive HIV epidemic threatens injecting drug users (IDUs) in Kabul¹, Afghanistan (MoPH 2014), and by extension potentially the general population (Des Jarlais et al. 2012).

Although opioid substitution therapy (OST) has been proven to reduce the spread of HIV and decrease injecting drug use in many parts of the world, including on a small scale in Afghanistan, political obstacles suggest that at this time it may not be a viable intervention there. This thesis, therefore, assesses the feasibility of implementing an alternative to OST as an HIV-prevention strategy, namely, a non-OST route-transition intervention (RTI) designed to encourage and enable opiate users to switch from injecting to smoking (also called chasing).

The emergence of an HIV epidemic in Afghanistan—along with the country’s massive illicit drug economy (McCoy 2010; UNODC 2013a, 2014a), high level of problem drug use (MacDonald 2007; UNODC 2009), and widespread psychological distress and social suffering (Cardozo et al. 2004; Eggerman and Panter-Brick 2010; Panter-Brick et al. 2009; Scholte et al. 2004)—is the accomplishment² (Reinarman 2005) of decades of imperial and civil war,

¹ And even more so IDUs in Herat City, where HIV prevalence (13.3%-18.4%) has consistently, since 2009, been much higher than that in Kabul City (2.1%-3.2%) (MoPH 2010, 2014; Ruiseñor-Escudero et al. 2014; Todd et al. 2007b, 2011).

² “Consequence” is the conventional term, but I use “accomplishment” for two reasons. First, I use it simply to engage with and make a connection to other scholarship. In this case, I am drawing not so much on the substance of Reinarman’s (2005) article, which deals with the historical social construction of the disease concept of addiction, as on its title (“Addiction as Accomplishment”) and the concept behind the word “accomplishment.” Second, and more importantly, a “consequence” can be the result of blind, unagentive, passive forces. Like the passive voice—“People were killed,” “Workers’ wages were cut,” “The population was displaced,” etc.—it can frame actions and results as simply happening, “naturally,” attributable to no responsible subject. By contrast, to say that something is an “accomplishment” implies that some rational, active, moral agent (a person, government, polity, organization, etc.) has wrought something (good or bad) and that that agent can be identified and held accountable (or praised, as the case may be) for what it has accomplished. My claim, then, is that many of Afghanistan’s ills (e.g., its narco-economy, high rates of problem drug use, and rising HIV rates) are not merely *consequences*. They are the *accomplishment* of historical political and economic actors and thus have an inescapable political and moral dimension to them, which to my mind “accomplishment” makes explicit. This is what I take Schwalbe (2008:36) to mean when he says that “inequality is an accomplishment.” “It doesn’t just happen,” he says, “like the wind or the rain; it happens because of how people think and act.”

geopolitical rivalry, military occupation, US strategic support for drug traffickers (Klassen and Albo 2013; Mercille 2013; Niland 2011), decimation of infrastructure and agriculture (McCoy 2010), widespread extreme poverty (Ruttig 2013; World Bank 2010), pervasive violence and insecurity (MSF 2014; Oxfam 2009), large-scale human displacement (Costs of War Project 2014; UNHCR 2015), and the imposition of an undemocratic warlord state that has subordinated human development to the interests of western powers, foreign capital, and local elites (Klassen and Albo 2013; Mercille 2013; Niland 2011). Given such a risk environment (Rhodes 2002) and evidence from similar contexts (Friedman et al. 2009; Hankins et al. 2002; Mock et al. 2004; Rhodes and Simic 2005; Rhodes et al. 2005; Spiegel 2004; Strathdee et al. 2006), it is unsurprising that “many Afghans seem to be taking drugs as a kind of self-medication against the hardships of life” and that, as a result, HIV infection is on the rise in Afghanistan (UNODC 2009).

UNODC (2009) estimates there are approximately one million adults (15-64 years) who use drugs regularly in Afghanistan, representing about 8% of the adult population. A more recent survey by the US Department of State (DOS 2012) suggests there could be at least 1.3 million adult drug users and about 300,000 children affected by drug use.³ Not only are these numbers

³ But some comparisons are necessary to guard against distorting the meaning and significance of these numbers. For example, UNODC (2009) reports that 8% of adults in Afghanistan use illicit drugs regularly and that this is twice the global average. But the numbers are similar for the US: 9.2% of Americans aged 12 and older reported having used an illicit drug (or used a licit one non-medically) in the last month in 2012 (NIDA 2014). The US State Department (DOS 2012) estimates that 2.6% of the urban population in Afghanistan uses opioids (defined as morphine, codeine, heroin, and synthetic pharmaceutical opioids). The *World Drug Report 2014* (UNODC 2014c:28) cites this statistic, calling it “high (in comparison with other countries).” And it is high compared to the global average (.7%), but it is not high compared to North America’s 4.3% (22). The report also notes that opioid use has increased globally over the last year and that most of that increase has been in the US (22), which trails only Canada (812.1855 ME mg) in its per capita consumption (749.7859 ME mg) of opioids for medical purposes (30), dwarfing such consumption in countries like Afghanistan (.3909 ME mg) (University of Wisconsin 2014). The State Department (DOS 2012) also estimates that 5.3% of the urban population and 4%-5% of the total population of Afghanistan uses drugs (defined as amphetamines, barbiturates, benzodiazepines, cannabinoids, alcohol, and opioids). But as noted above, 9.2% of Americans use *illicit* drugs alone (NIDA

high, but they also represent a trend of dramatic increase in drug use. From 2005 to 2009, the number of regular opium users increased by approximately 53%, from 150,000 to 230,000, while the number of regular heroin users increased by 140%, from 50,000 to 120,000 (UNODC 2009). Moreover, there has been an increase in the prevalence of injecting drug use, a practice thought to be imported by Afghan refugees from neighboring Iran and Pakistan (MCN 2013; Saif-ur-Rehman et al. 2007; Todd et al. 2012b). This is of special concern, for it introduces a host of well-documented risks and harms, not the least of which is HIV infection and syringe-mediated syndemics (Pates et al. 2012; Bulled and Singer 2011).

The Afghan Ministry of Public Health (MoPH 2014) estimates there could be as many as 23,000 IDUs in the country, most of whom reside in urban districts. Kabul City⁴, with 12,541⁵, has the highest absolute number and concentration of injectors in Afghanistan. According to the most recent data (from 2012), Kabul also has the second highest⁶ HIV prevalence among IDUs

2014). That figure doesn't include alcohol, as the State Department figure for Afghanistan does. The prevalence rates for just alcohol use in the US for those 18 and older are 87.6% (lifetime), 71% (past year), and 56.3% (past month) (NIAAA 2014). Nor does that 9.2% include tobacco, which 19% (46.6 million) of US adults smoke in the form of cigarettes (Agaku et al. 2012; CDC 2012). And the harmful effects of smoking are staggering: 443,000 premature deaths result each year from smoking or exposure to second-hand smoke, and 8.6 million people live with serious smoking-related illnesses (CDC 2012). Children, too, are affected. In fact, 54% of children (3-11 years) in the US are exposed to second-hand smoke and thus also to the risk of serious smoking-related illness. 150,000 to 300,000 children under the age of 18 months experience lower respiratory tract infections due to exposure to second-hand smoke (CDC 2012). Therefore, readers of the story of Afghan drug use as presented in official reports, such as those frequently cited in this thesis, are encouraged to keep this other side of the story in mind, especially when encountering reports of many drug users (up to 50% in southern and northern Afghanistan) giving opium to their children (UNDOC 2009) or of 300,000 Afghan children being affected by drug use (DOS 2012). Keeping both stories in mind does not diminish the gravity of Afghanistan's drug-related problems, but it does present an obstacle to feelings of superiority or self-righteousness, which reading the Afghan story in isolation could (and, arguably, is often meant to) provoke.

⁴ Hereafter, unless otherwise noted, Kabul refers to Kabul City, not Kabul Province.

⁵ This number varies across reports, suggesting both an important increase and the difficulty of estimating such statistics. The World Bank (2008) estimates 1,251 IDUs in Kabul City (2006-07). Maguet and Majeed (2010:119) report that "Kabul city has . . . 15,000-20,000 heroin users (mainly injectors)." The Ministry of Public Health (MoPH 2014) reports 12,541 IDUs for 2012.

⁶ Herat has the highest prevalence at 13.3% (MoPH 2014). Previous surveys have detected prevalences in Herat as high as 18.2% (MoPH 2014) and 18.4% (Ruiseñor-Escudero et al. 2014) and as low as 3.24%

in the country at 2.4% (MoPH 2014). Previous studies based on data from 2005 to 2009 (Todd et al. 2007b, 2011; MoPH 2010; Ruiseñor-Escudero et al. 2014) found similar rates (2.1%-3.2%), suggesting the epidemic is relatively stable at present (Ruiseñor-Escudero et al. 2014; Todd et al. 2011). However, these same studies (as well as Todd et al. 2008 and MoPH 2014) also found high or significant rates of injection-equipment sharing, purchase of sex, low condom use, and men having sex with other males. Such HIV-risk behaviors amidst the accomplished noxious environment of contemporary Afghanistan indicate therefore that the stability of the epidemic in Kabul may be only apparent or short-lived. Indeed, ample evidence demonstrates that injection-driven epidemics can escalate rapidly, even explosively. For example, HIV prevalence increased from 0% to 50% in six months among IDUs in northeastern India (Sarkar et al. 1993), from 1% to 43% in one year in Bangkok (Choopanya et al. 1991), from .625% to 23% in less than a year in Karachi (Bokhari et al. 2007), and from 9% to 51.5% in approximately one year in Sargodah, Pakistan (Emmanuel et al. 2009). HIV incidence in Kaliningrad, Russia, primarily among IDUs, increased by 6,744% in one year (Liitsola et al. 1998).

Fortunately, ample research indicates how to prevent and curtail HIV transmission among IDUs, namely, by scaling up combined provision of needle and syringe programs (NSPs), opioid substitution therapy (OST), and antiretroviral therapy (ART) (Degenhardt et al. 2010; Des Jarlais 2010; Strathdee et al. 2010; WHO et al. 2012). Each of these interventions exists in Afghanistan and has received governmental sanction, but their scale is vastly inadequate (MCN 2012, 2013; MoPH 2014; Todd et al. 2012b). For example, these three harm reduction measures combined cover only 25% of the 19,000-23,000 IDUs in the country (MoPH 2014). Only 4.2% of people living with HIV (MoPH 2014) and .6% of HIV-positive IDUs (Petersen et al. 2013) are using

(Nasir et al. 2011). See Ruiseñor-Escudero et al. 2014 for a possible explanation of the extreme spread of this range.

ART. Only nine NSPs operate in the country (Petersen et al. 2013). In 2007, only three were in Kabul (Todd et al. 2011), a city with over 3 million people and more than 12,000 IDUs. Only 71 people have used OST in the last three years (MoPH 2014).

Knowing what to do and being able to do it, however, are very different things (Pisani 2010; Singer et al. 2005). At least two obstacles impede implementation of effective HIV-prevention measures in Afghanistan. First, problem drug use, HIV, and human development in general do not appear to be primary concerns of the foreign governments that have invaded and occupied Afghanistan and that now fund 85% of its budget (\$3.7 billion), nearly half (\$1.6 billion) of which goes toward “security.” For example, the US spent \$416.2 billion on military operations in Afghanistan from 2001 to 2012, while providing, during that same period, only \$25.2 billion in aid—much of which wound up back in the donor countries via contracts with donor-country service providers. While the US military spends \$100 million a day in Afghanistan, all international donors combined spend only \$7 million a day (Ruttig 2013). Put differently, other calculations show the US spending \$1 million a year per soldier in Afghanistan and international development donors spending a meager \$93 a year per Afghan (Mercille 2013). In these terms, the \$5 million from international donors that accounts for nearly all (\$5.3 million) spending on HIV/AIDS in Afghanistan in 2013 (MoPH 2014) equals what the US spends annually to keep five soldiers in the country. Meanwhile, Afghanistan has the highest infant mortality rate in the world (CIA 2015b), 36% of Afghans cannot meet their basic needs, over 80% of the population cannot access safe water (World Bank 2010), 60% of children are malnourished (Ruttig 2013), problem drug use is rising sharply, and a potential explosive HIV epidemic is in the making (MoPH 2014; UNODC 2009). In short, ample resources exist to meet

the enormous unmet accomplished need in Afghanistan, not the least of which pertains to drug use and HIV, but the political will and proper balance of power do not.⁷

Second, abstinence-based approaches to drug use in Afghanistan predominate (Todd et al. 2012b). Recent reports (MCN 2013; UNODC 2009, 2014b) give little attention to harm reduction measures (e.g., NSPs and OST), emphasizing instead drug-use prevention and rehabilitative treatment, despite harm reduction's explicit incorporation into the country's National Drug Demand Reduction Policy (MCN 2012). Plausible reasons for the predominance of abstinence-based approaches over harm reduction approaches include Islam's proscriptions on the use of intoxicants (Hasnain 2005)⁸, involvement of the abstinence-promoting Colombo Plan (Todd et al. 2007a, 2012b) in developing and implementing drug policy in Afghanistan (MCN 2012, 2013), and the US State Department's role as the largest funder⁹ of treatment in Afghanistan. After all, the US bans federal funding of NSPs inside its own borders (Castillo 2014), only 16 of its states have legalized NSPs¹⁰ (LawAtlas 2014), and it remains the longstanding leader of a punitive, militarized abstinence-based approach to drug use¹¹ at home and abroad (Chien et al. 2000; Reinerman and Levine 2013; Singer 2004).

⁷ Although the recent election of Ashraf Ghani could potentially alter this situation somewhat, his quick signing of the new security pact with the US (Walsh and Ahmed 2014), his lifting of the ban on night raids (Nordland and Shah 2014), allegations that his election campaign (as well as those of his opponents) may have relied upon drug money (Nordland 2014), and the inclusion of Rashid Dostum—"a warlord par excellence" (Riedel 2014), "known killer" (Ghani 2009), and alleged war criminal (Democracy Now! 2014; Lasseter 2008)—in the unity government as vice president (Nordland and Walsh 2014) is not encouraging.

⁸ But see Kamarulzaman and Saifuddeen 2010 for an interpretation of Islam that sees it as sanctioning harm reduction. Also, see Todd et al. 2007a for a review of harm reduction measures in the three Muslim countries of Afghanistan, Iran, and Malaysia.

⁹ It is worth noting, however, that this figure must be quite modest given that only \$2 million (1%) of the Afghan health budget was allocated to drug-demand reduction in 2011 (MCN 2013).

¹⁰ Yet NSPs are not restricted to these 16. They exist in 33 states and the District of Columbia (amfAR 2014).

¹¹ Although there are hopeful signs that the US-led war on drugs and drug users may be abating somewhat (e.g., changes in marijuana laws in several states, growing support for increased access to

These two obstacles present serious challenges to curtailing the spread of HIV among IDUs in Afghanistan and preventing its potential transmission to the broader population. The controversy surrounding OST is a particular case in point. Given the importance of OST (Bruce 2010; MacArthur et al. 2012) as an element in the recommended combined-intervention approach to HIV among IDUs (Degenhardt et al. 2010), it is particularly troubling that OST remains only a single pilot program in Afghanistan and that the Ministry of Counter Narcotics has repeatedly blocked the importation of methadone despite its own sanctioning of OST in the National Drug Demand Reduction Policy (MCN 2012), a very positive third-party evaluation of the pilot program (Maguet et al. 2012; Todd et al. 2012b; UNODC 2013b), and the WHO's including methadone on its list of essential medicines (WHO 2013). Therefore, because the scale-up of OST seems highly unlikely in the near term, combined interventions are necessary, and urgent action is needed¹², physician and public health researcher Catherine S. Todd, MD, MPH, and colleagues investigated the feasibility of a non-OST route transition intervention (RTI) as an alternative to OST and a complement to the general HIV-prevention, drug-treatment, and harm reduction armamentarium.

RTI refers to interventions that encourage and help enable users to transition to less harmful methods of consuming the same drug. Nicotine patches and OST are examples of such interventions. Efforts to facilitate transition from injecting to smoking heroin is another (Bridge 2010; Hunt et al. 1999). Given the numerous harms associated with injecting (e.g., bacterial and viral infection, infectious disease syndemics, overdose, and vein damage), prevention of

naloxone, and the recent appointment of a drug czar, Michael Botticelli, who supports a public-health approach to drug use).

¹² HIV epidemics among IDUs are best averted by implementing prevention measures before prevalence reaches 5% (Des Jarlais 2010). Once it reaches approximately 20%, they can become “self-perpetuating” (Des Jarlais et al. 2000). As already noted, rates ranging from 2.1% to 3.2% have been observed among IDUs in Kabul (MoPH 2010, 2014; Ruiseñor-Escudero et al. 2014; Todd et al. 2007b, 2011).

initiation to injecting or transition to non-injecting routes of drug administration can significantly reduce the harms associated with drug use (Bridge 2010; Des Jarlais et al. 2014).

Transitions from injecting to non-injecting drug use among IDUs in New York City may have protected against HCV infection (Des Jarlais et al. 2014). Distribution of foil¹³ in the UK to encourage heroin injectors to switch to smoking had positive results. Whereas 46% of participating IDUs reported having smoked heroin at least once in the four weeks prior to the intervention, 85% reported at its conclusion that they had smoked heroin at least once when they would have otherwise injected (Pizzey and Hunt 2008). A similar study in Germany found that 65.3% of participants used the provided foil, choosing to smoke rather than inject heroin (Stöver and Schäffer 2014). Combined with these findings, the fact that smoking (and oral ingestion) has historically been the dominant means of consuming opiates in Afghanistan (Saif-ur-Rehman et al. 2007), a prior study of Kabul IDUs has noted a high rate (27.6% - 49.7%) of switching from injecting to smoking (Todd et al. 2012a), and recent surveys (MCN 2011; UNODC 2014b) of drug users in Afghanistan have observed significant rates of heroin smoking (as high as 94.6%) suggest that a smoking RTI could constitute part of a solution to the emerging HIV epidemic in Afghanistan in general and the obstacles to OST in particular. The following sections describe the investigation of that potential and report its findings.

METHODS

Participant Eligibility

The aim of this study was to assess the feasibility of adding to existing harm reduction programs in Kabul an RTI to encourage and enable drug injectors to transition to the less risky drug-administration route of smoking. Data collection occurred under the direction of Catherine

¹³ Smoking (or chasing, as in “chasing the dragon”) heroin involves heating heroin powder on a piece of aluminum foil and inhaling the fumes through a small tube.

S. Todd and colleagues between June and November 2012 in Kabul, Afghanistan. The data and analysis presented here concern only the Stakeholder Component of a larger formative study that also comprised a Client Component, which involved injecting drug users in Kabul. Stakeholder participants were Dari or Pashto speaking adults representing the police, the Afghan Ministries of Counter Narcotics (MCN) and Public Health (MoPH), and harm reduction programs in Kabul. Prior to data collection, approval was granted by the institutional review boards (IRBs) of the MoPH, Islamic Republic of Afghanistan, and Columbia University,¹⁴ and approval of data analysis was granted by the IRB of the University of Connecticut.¹⁵

Study Design and Measures

Study participants included 15 key stakeholders who were recruited for semi-structured in-depth interviews (IDIs) from institutions and organization located in Kabul. The groups represented were the MCN (n=2), the MoPH (n=2), police and workers involved in programs that address problem drug use (n=5), and program managers and outreach workers involved in harm reduction programs (n=6.) The IDIs were supplemented by a focus group discussion (FGD) that was conducted with harm reduction staff who were not part of the IDIs.

Prior studies informed design of the interview guide, which was pre-tested for face and content validity on three stakeholders who were not among the 15 study participants (Todd et al. 2009b, 2011). The IDIs sought to gauge participants' knowledge about harm reduction practices and existing harm reduction programs and to discover the challenges that such programs face. The IDIs also involved the reading of a description of an RTI program model by interviewers, after which participants were asked about the desirability of such a program, what challenges it might face, and how different groups might react to it. The FGD centered on similar questions as

¹⁴ Catherine S. Todd was affiliated with Colombia University at the time the study was initiated.

¹⁵ University of Connecticut IRB approval applies to William Tootle and Merrill Singer.

well as issues of why people begin to use drugs in general and initiate injecting in particular and whether any harm reduction programs were already encouraging injectors to transition to smoking.

Data Collection

Study staff identified participants at their place of employment. Informed consent was obtained, and participants were given the option of conducting the interview at their own or the study's office. For interviews conducted at the study office, participants were offered a meal. The FGD occurred at the study office, where participants were compensated with a meal. Prior to recording, participants selected pseudonyms. One investigator moderated the discussion with another staff member present to document main themes and non-verbal communication.

Data Analysis

At the study office, all IDI and FGD files were maintained on a password-protected computer, transcribed in Dari, and then translated into English. One of the investigators reviewed translations against the original transcripts for accuracy. Final anonymized English transcripts were transferred to me via secure connection.

I used the qualitative-data-analysis software HyperRESEARCH (3.5.2) and followed Bernard and Ryan (2010) and Creswell (2013) in coding, analyzing, and abstracting themes from the data. Specifically, this involved recursive reading of the transcripts, identifying and coding salient features of the data, calculating code frequencies as a measure of the significance of coded material, and arranging codes into themes and subthemes. The two main themes (barriers and benefits) derive from the survey instrument itself and thus reflect the purpose of the study, while the subthemes emerged from a reading of the data. Because RTI is a harm reduction measure, investigating its feasibility required also exploring participants' views on harm

reduction in general and eliciting their descriptions of existing harm reduction services and community members' perception of them. The two main themes therefore refer both to RTI in particular and harm reduction in general. They also refer to treatment because, although not part of the instrument, participants repeatedly discussed it.

Barriers to harm reduction, RTI, and treatment constitute the most salient primary theme in the data. The term *barriers* thus summarizes numerous secondary themes. Participants discussed many different barriers to harm reduction, RTI, and treatment. Some they linked only to one of these three intervention dimensions; others they linked to all three. Yet even when a specific barrier (e.g., security) is linked by a participant only to, for example, existing harm reduction programs, that barrier obviously applies to RTI and treatment programs as well. Consequently, many barrier subthemes appear as barriers *in general*—that is, to existing harm reduction services, the potential RTI at the center of this study, and existing treatment services—and do not specify any one of the three intervention dimensions. When a barrier *is* dimension-specific, however, that is made clear. Discussion of the other primary theme (benefits), however, concentrates on the benefits of RTI in particular rather than those that apply in general to all three. But, as will become apparent, any singular focus on RTI is hard to maintain because treatment perpetually gets pushed into view. Themes and subthemes are arranged approximately in descending order of salience based on the number of participants who expressed them. Finally, I have made only occasional and very minor alterations to the transcript excerpts for clarity. Most of the bracketed text was inserted by the translators. I have added a few additional bracketed insertions only where it seemed necessary for clarity.

THEMES

Barriers to Harm Reduction, RTI, and Treatment

Five kinds of barriers emerged from the data: cultural views on drug use, knowledge and opposition, institutional challenges, physical and economic risk environment, and route of drug administration. Discussion and illustration of each of these barrier subthemes follows.

Cultural Views on Drug Use

1. Stigma surrounding drug use

Participants reported that drug use and drug users are highly stigmatized in Afghanistan, as is the case in many other parts of the world (Friedman 1998; Room 2005; Singer and Page 2014), resulting in barriers to implementation of and access to harm reduction and treatment services (Ahearn et al. 2007; Link and Phelan 2006; Simmonds and Coomber 2009). The stigma that they suffer is pervasive. As one participant (a social worker) put it, they are “reviled” and “expelled” from society.

They [addicts] don’t have any place in the society, they are isolated from the society, and can’t live in the society. They are reviled, they can’t live in the society. . . . The people don’t like them even when they are treated. Ten times they are expelled, they are not seen with a good sight because an addict is a thief, pocket-ripper, he can do anything. The people don’t think of them as a good person and when they are treated, they say that he is not washed out so that [while] all his acts are cleaned his stealing remains. When there is no work, he certainly would steal; their life is difficult in the society, they are expelled from the society. . . .

Another social worker described how stigma impedes drug users’ everyday movement and mobility in society.

Like the normal people who can support their family and the way that they can go everywhere, the addicts can’t be like them in the society. They are seen as without a personality [a disrespected person], they are seen as low character and status people; they are seen like a thief or as a murderer.

Stigma also affects the ability of agencies to implement services for drug users.

The residents of the district have discrimination against them. Even in some hotels that we wanted to take as the safe place, when we mentioned the addicts, we said that monthly we would give you this much money. They completely refused it, they said that “no, when you bring the addicts in here, we don’t need your money, we can’t give any service.” There is a lot of discrimination towards them. [NGO project supervisor]

As already noted, stigmatization of drug users is pervasive. Government actions embody and reproduce it.

In Kabul, as I said there’s stigma, even in high governmental offices. There’s discrimination against them; they are not seen as humans. Government, the Ministry of Public Health have a great attention in the harm reduction policies but the Ministry of Counter Narcotics have fewer policies or even no policies in this field. The Ministry of Interior Affairs, from the security point of view, they interfere and collect and gather all the drug users, but they don’t know the outcome of such an act. They imprison them and don’t know the bad outcomes of it; they don’t have any better solution than this. [NGO project manager]

Family members are not immune to its influence.

Yes, it [stigma] is a big danger. Like I said before, that even the families do not see the addict with a good eye, so according to this basis, all the society see the addicted with an insulting and insolent eye. They say like that “he is a criminal” and in everywhere something happens, they hold him accountable, that you have done this, which he didn’t commit it. [police officer]

Service providers are not immune either, as a doctor’s comments suggest. They imply a causal link between character flaws (in this case, laziness) and addiction, illustrating how stigma can obscure the social and structural origins (B. Alexander 2000; Baer et al. 2013) of problem drug use by framing it as the pathology or inadequacy of individuals.

Well, firstly the addicts, the ones who use drugs, a special characteristic of them is laziness. They are lazy. . . . They are lazy and they are always in one corner.

Stigma, however, is not confined to drug users. Its spoiling reach extends also to those who are merely associated indirectly with drug use, such as drug user family members and outreach workers.

Their children are not taken to the schools They [headmasters] don’t take [accept] them to [into] the schools, lots of them are not taken, they don’t take the children. They

say that you are an addict and you would addict other students. . . . They don't take them, they beat them. Just now, all these older boys [points to a hospitalized IDU] are taken away [out] of the school [and told] that you are addicts and you will addict other boys. [social worker]

When we go to the field, the people [but not the police] talk behind us [back biting], they bother and tease us, but we take it easy and say we are serving for God and it is our work. We don't care about the things [that people say]. [social worker]

Q: So even when he is on his way to seek care from a harm reduction center, they bother him and stigmatize him?

A: Yes, this itself is a problem, so it is a big shame, to the patient. The people don't see them with a good eye; they don't see them as [a] patient. If he is seen as a patient, then it would be possible that these patients may find a feeling that I am a patient, and I should do this job [quit drugs]. [police officer]

Interviews with Afghan drug users from the Client Component of the study confirm these reports of the extreme stigmatization of drug users and the consequent exclusion and discrimination that they face (Santelices n. d.).

2. Dominance of abstinence-based approaches to drug use

The preference for treatment and abstinence over harm reduction pervades the data, reflecting the emphasis by recent reports (MCN 2013; UNODC 2009, 2014b) on drug use prevention and rehabilitative treatment and supporting previous findings (Todd et al. 2009a, 2012b) that abstinence-based treatment approaches predominate in Kabul. This may be explained by the factors already mentioned above (Islam's proscriptions on intoxication and the involvement of abstinence-promoting governments and organizations in funding and developing drug-related programs and policies in Afghanistan), as well as by the fact that many study participants work in organizations that provide treatment. Whatever the case, the preference for treatment and abstinence appears in the data in two ways.

First, in response to questions about harm reduction services, several participants responded by discussing abstinence-based treatment programs. Second, participants frequently described treatment and abstinence as the ultimate goal of any service (NSPs, counseling, transition to smoking, etc.) for drug users. In fact, the majority of participants expressed some form of this view. A doctor's response to a question about the benefits of RTI illustrates this point well.

A: One thing more it is that . . . we usually want to change the IDUs to smoking, and then do the treatment on them, [but] we can't bring the IDU patients to treatment, and if they are brought to it [treatment through RTI], then it is an important and qualified way.

Q: That is, they would be easily and quickly treated?

A: Quickly they are treated and the number of IDU patients would become less, and the number of patients under treatment would increase.

It should be noted, however, that one participant (an NGO project supervisor) reported that drug users themselves are requesting detoxification and treatment.

A: As we go to the field in these days, and are in contact with them, they are requesting . . . detoxification, the detoxification centers.

Q: Treatment?

A: Yes, they say that we reduced the drug use, we changed from injection to smoking, and make the smoking less, we want to go to the detoxification, and we want to abandon the drugs. Most of them want detoxification.

3. Segregation of drug users from general population

Segregation relates to the theme of sanctioned space for drug use (discussed below), but it is not limited to that theme. Segregation refers to a broader issue of which sanctioned space is but a part. It has more to do with a kind of benevolent othering that proposes to help drug users by removing them from places and situations of harassment and injury, from people and

encounters that thwart their attempts at self-improvement through participation in harm reduction or treatment programs.

Several participants recommended some form of segregation as a way around the stigmatization that drug users experience and the barrier to services that it presents, but they seem unaware of the possibility that such a policy itself could be a form of stigmatization and one, moreover, that could reinforce the very stigma that it aims to circumvent. The segregation theme thus further illustrates the pervasiveness and subtlety of both the stigma surrounding drug use and drug users and the expulsion that it warrants and activates. To be sure, refuges or shelters, which a social worker proposed establishing, would certainly benefit indigent and harassed drug users, but it is important to recognize the subtle (or not so subtle) and detrimental operation of stigma that segregating interventions can effect. The suggestion by a doctor, for example, that “if they [drug users] are transferred to a place [i.e., a service center away from business areas] . . . it would be more beneficial, and the people would get rid of their brawling” represents such an intervention that warrants critical examination, as does the following proposal by a police officer.

We have this one appeal from the government as a citizen of this country, that in a far region, for example, in Deh Sabz in Khak Jabar district far from the aggregation of local people, should be a base, a big hospital made for them [drug users]. They should be taken under continual treatment, not like now in the resident area, a hospital [NGO] came with extravagant money, and rented a house, and keep the addicts for 15 and 10 days there, just so they are happy. . . . As a first step, a hospital should be made for them, a very fundamental hospital should be built for them. . . . Third, all the addicts should be collected in a very caring method, not with the force of stones and stakes, or with kicks. They are humans; we should respect their human dignity. Fourth, the addicts should be gathered from the capital in a very good way, and should be taken under continuous treatment, under continual treatment.

Such policies of “social and spatial segregation” could very well further stigmatize and marginalize drug users, as Christopher Smith (2011:306) has observed among methadone clients

in Toronto. Moreover, such policies ignore or obscure the social, political, and economic origins of problem drug use (B. Alexander 2000; Baer et al. 2013)—which, as I have already noted, stigmatization facilitates—and share a degree of affinity with perhaps the most extreme expression of the sociospatial segregation of drug users, namely, their mass incarceration in the United States (M. Alexander 2012).

4. *Collective harm related to individuals' drug use*

Nearly half the participants noted that drug users not only harm themselves, but also society as a whole. For example, one doctor stated that drug users' "risk is not only for themselves, but it is more to the whole society" and another that "they don't know the calamity it [drug use] brings to their families and how harmful they be for their family, country, and society."

This line of argument could be used to gain support for controversial harm reduction measures like RTI by appealing to the broader society's self-interest. Therefore, the theme of collective harm could be seen as a *facilitator* of RTI and other harm reduction programs and not a barrier, as I have classified it. But such an argument risks blaming the victim and thus exacerbating the harms of problem drug use to the degree that it conceals the reality that problem drug use is a structural accomplishment (B. Alexander 2000; Baer et al. 2013) and thereby forecloses the possibility of accomplishing counteracting structural or political-economic interventions. Moreover, contrary to the progressive and activist roots of harm reduction (Smith, 2012), such a framing (mis)portrays harm reduction as protecting non-users ("us") from dangerous, diseased drug users ("them") (Brook and Stringer 2005) rather than reducing the harm and suffering that users experience *because of*, one might say, "us"—that is, because of systemic structural inequalities and inequities, discriminatory laws, punitive drug policy,

scapegoating and stigmatization, etc. For these reasons, then, I classify emphasis of collective harm as a barrier.

Knowledge and Opposition

1. Lack of knowledge about harm reduction and the harms of drug use

Participants frequently noted that a significant barrier to accessing and implementing harm reduction services is a lack of knowledge among drug users and throughout society in general about what harm reduction is (e.g., not enabling), what its benefits are, what the harms of injecting are, etc. These views reinforce Stanekzai et al.'s (2012) finding that Kabul residents “seemed relatively unsupportive of harm reduction, potentially representing lack of knowledge or misconceptions about harm reduction.” An NGO project manager expresses this theme well.

By and large, the deficiency and shortage of knowledge and awareness about the projects of harm reduction between the drug users and the society, between the people is the main and fundamental reason [for addicts' trouble accessing harm reduction services]. The harm reduction is not explained and clarified to the people in the way it should be. It is not said to them that why and for what purpose do we need the harm reduction? Why do we supply or provide the harm reduction and this is why they have a wrong thought about the harm reduction in the society. They think that the services of harm reduction increase the drug users and drug use, that giving injectors syringes and needles is in a way persuading them and leading them in a wrong way. There is no general awareness and knowledge and even knowledge between the society and between the policy makers.

In other words, lack of knowledge encourages opposition. In fact, many participants suggested that much harassment of drug users and opposition to harm reduction stem from inaccurate knowledge about harm reduction, addiction, and the public health implications of injecting drug use. A few also pointed out that some drug users simply do not know about existing services, which is clearly a barrier, albeit one that could be comparatively easy to overcome with investment of sufficient resources.

2. Community opposition to harm reduction and RTI

Community opposition to harm reduction is closely related to the themes of stigma and lack of knowledge. It refers to community-member interference, harassment of drug users and harm reduction workers, and backlash due to lack of knowledge about harm reduction or prejudice against drug users. It is associated with the idea that harm reduction “motivates” or “enables” drug use. This is a challenge that an RTI could very well face.

[T]he people don't know anything about this [RTI]. They don't have any information. Possibly they would say that you are motivating them. They don't know that I am not motivating them; instead, I am preventing diseases this way, that way. If we give them information about the program, the people would show satisfaction; and if some of them don't know anything about it, they would say certainly they would say something about it nowadays. The nonsense talking is very frequent in Afghanistan. [social worker]

Fortunately, however, many participants stated that community opposition could be overcome by public-awareness campaigns, coalition building, and inclusion of the community in planning and implementation of programs. Some cited personal experience of community support as evidence for such claims. The same prescribed support-winning actions appear to apply equally to both community and police (see below). For example, when asked what society's reaction would be to a smoking RTI, a social worker stated:

Well at first, we work with the people and tell them about the program of smoking and explain that the injection has lots of harms, such as it transmits contagious diseases. If we work with the society, the environment, slowly by the passage of time that it has this kinds of benefits and smoking doesn't cause any transmission of viruses and in spite that it doesn't transmit viruses it can also be decreased daily on addicts. In that case, the society the environment would know and help and collaborate with us.

Likewise, regarding an RTI, a police officer said, referring to many families affected by problem drug use, “They would welcome this work, these people.” As support for this claim, he relayed the moving scene of “caring and desperate” mothers kissing their drug-paralyzed sons amid the filth “under the bridge of Pul-e Sokhta,” standing near and kissing them despite the “blackness,

smell, and stink” that would prevent anyone else from going near them, and crying out “What should we do with our sons?” Of course, such pain and desperation do not guarantee community support for harm reduction measures like RTI—in fact, they could be misperceived as part of the problem and thus decried—but they do imply a potential openness to measures like RTI that could be appealed to and properly informed. In other words, a potential base on which community support for RTI might be built exists. A campaign to build support might, for example, start with those immediately impacted by addiction and work through their social networks to raise awareness about drug use, addiction, and harm reduction.

3. Police opposition to harm reduction/RTI and harassment of drug users

Police opposition to harm reduction services and harassment of drug users appears to be common in Kabul. Participant responses resonate with the finding by Todd et al. (2009b:115) that drug users in the city identify the police as “the entity most likely to cause [them] problems.” This could pose a particularly significant barrier to RTI given that drug users often switch to injecting, which is easier to conceal than smoking, to avoid police harassment (Todd et al. 2009b, 2012b). In other words, police harassment discourages smoking, making police behavior a significant obstacle to the implementation of an RTI. And because harassment encourages risky injecting (needle sharing, rushed injecting, use in unsanitary conditions, etc.), it also functions as an obstruction to harm reduction in general.

Part of the problem is spatial. “There is no knowledge between the security forces,” an NGO project manager said, “so they think that . . . beating them [addicts] is the only solution for it.”

Q: So you mean that when an addict wants to come to the centers, there is an obstacle in their way, like the police?

A: We have this problem. We are active and provide service in the Dasht Barchi district of Kabul. Every day, the addicts are beaten by the police and the counter narcotics police to go away from this place. And since the addicts don't have a distinct place for themselves, they gather in any place and the local people living there beat them, [the police] arrest them and even to the level of death. They ask them to go away from this place, and they scatter from that place. There is no other place, a specific place for them; so they spend day and night under the bridge, on the streets, and in the ruined places. They go from one place to other. This is why they don't have access to the centers which provide them services.

However, as with community opposition, many participants suggested that police opposition and harassment can be overcome with education and diplomacy. For example:

At first we had some problems. We had problem with the police because they scattered them [drug users]. When we gathered them, they scatter after they saw the police. After the agreement we had with the police, they are helping us now in the 5 districts and we don't have any problem now. [NGO project supervisor]

The reaction of the police, in my opinion, if this program [RTI] is started directly like this, the reaction would be very serious. We still have this problem with police, it is been a few years that this program [either harm reduction programs in general or a kind of RTI program; unclear what program the participant is referring to] has started, but still we have problems with police. The training and orientation of the police about this program is very important. Before this program is started, they should have awareness. And when they have information and it is explained to them in the right way, then I would say that they won't have this much reaction. [government program officer]

Added a physician:

The police, naturally their reaction [to RTI], if god is willing, would be positive. . . . If god is willing, there won't be any objection to this program, and other when a new program is started, before it is implemented, the police should be made aware of it, such as to how this program is implemented, what would be its benefits, and what would be the harms of it. If this is in every district, in every field, the program would be carried on well. If there is no awareness, not only the police but the Wakeel/Arbab [community representative] or mullah [religious scholar] would prevent such programs, so before everything, they should be made aware of the details of the program and it should be said to them, we are implementing this program to see that the children, the people, and the patients are safe from the risk. It is possible that they would make some annoyance [if they are not informed].

4. *Intimidation or interference from drug traffickers*

Approximately half of the participants claimed that drug traffickers would react negatively to an RTI or recounted actual interference from them. For example:

Their [drug sellers'] first reaction [to RTI] will be that it's a big economical loss to them. If we treat a patient, for example, in Kabul, we have hospitals that completely treat the patients. For example, in one time when they check out, they check out 30 or 35 patients. They spend 40 or 45 days at the hospital. Each of them at least spend 200 or 300 afghanis [the Afghan currency], on drugs every day. If they spend one dollar on drugs, so calculate how much it will be? It will be 30 or 35 dollars and it's a big loss to the sellers. In fact, they try hard to defame the program. They try to do this through people who are with them, the ones who work in the governmental offices. They are in government or in districts or in security. They are their partners. [doctor]

Interestingly, it is the presumed close association between RTI and treatment and thus abstinence (see below)—reflecting the already noted predominance of abstinence-based approaches—that allows this participant to predict drug trafficker opposition to an RTI. Another participant, in response to a question about what obstacles drug users face in accessing harm reduction services, recounted actual interference from drug traffickers.

A: That is because there are many drug dealers. The problem is that there the dealers sit on our way. Many times they have taken our way in Bagh Ali Mardan. Even they had guns and wanted to explode our car. We have told them that, brother, we are here to just carry the message to them. Anybody who wants to go voluntarily, they can. We don't force them to do that. We are not police and we have told them not to behave so bad with us. Even they would have taken out the gun and showed us and told us that if we come again, they would kill us.

Q: And you tell them that you don't prevent them but you change them from one type [of drug use] to another one?

A: We change them from one type to another very simply, but still because of their business and five afghanis, they hinder us. [social worker]

However, many participants claim that drug traffickers would not interfere with an RTI precisely because, as the previous participant noted, an RTI is about route *transition* and not cessation per se. For example:

Harm reduction programs are mostly not against the drug sellers. They [harm reduction programs] want to decrease the harms the addicts are facing. In this case, they [drug dealers] don't have a problem with the project. Because it is not anti-intoxication, or making them abandon it, the programs of harm reduction just say to them that in the counseling that you abandon it, and they just do a counseling for them. They don't have any other specific program. [NGO project supervisor]

I don't think that they would show a strong reaction [to an RTI]. For them, the consumer doesn't matter whether he is an injector or a smoker. [NGO project supervisor]

These people who they call smugglers or the bungs, or whatever they call them, these people are not happy of any services. They don't want to have any problems in the programs that they are implementing, or the patients [buyers, drug users] become less, or the patients are motivated like they decrease the amount of the drugs, because in here [i.e., presumably, in programs that lead users to decrease their drug consumption] their supply [of clients] decreases, the selling of them it is decreased. When it is decreased, then naturally it would have an effect on them. It does not mean that bringing them to smoking will make them angry; definitely regarding the drugs, every step that is taken it would have an effect on them. But they would not be very much affected by this [since RTI only changes route of drug administration]. [doctor]

The drug seller won't have any problem in this [RTI]; the consumption is the same. [social worker]

Still he [drug seller] becomes happy; it [drug] won't be banned. [social worker]

Finally, as with community and police opposition, some participants suggested that whatever antagonism toward an RTI might come from drug traffickers, it could be countered. For example, both a doctor and a social worker recommended that hypothetical RTI implementers actually try to reach out to drug traffickers and educate them about the program's aims to preempt or limit their negative reactions. Another social worker went further, suggesting that perhaps drug sellers could be persuaded from selling drugs if only they knew their harms and Islam's teachings regarding drug use. Drug dealers "don't have information and that is why they are selling drugs," she said. This view, however, ignores the fact that the opium trade is worth about 14% of Afghanistan's GDP (UNODC 2013a) and that unemployment is at about 35% (CIA 2015a). In other words, it ignores, among other things, the significant role that poppy

cultivation, opium production, and drug trafficking play in Afghanistan's political economy and the extent to which livelihoods depend on drug sales within the country.

Institutional Challenges

1. Inter-agency cooperation and coordination

Lack of cooperation, collaboration, and coordination between stakeholder agencies and organizations emerged as a salient barrier to existing harm reduction services and as a salient potential barrier to RTI. According to participants, the success of existing and future programs like RTI depends on substantive, broad-based cooperation between all relevant institutions and organizations. Asked what challenges an RTI might face, a doctor stated:

A: There are challenges, if your program is introduced through a meeting to all stakeholders, for example governmental offices and NGOs, and from every organization there be a participant in this field, then I think that there won't be any problems.

Q: You mean that one challenge is that if the corresponding organizations are not involved, we will face the opposition of the corresponding organizations?

A: You would definitely face [these problems].

2. Organizational capacity

Many participants complained of insufficient harm reduction and treatment organizational capacity to meet the needs of drug users, echoing reports (MCN 2012, 2013; MoPH 2014) that there is a large gap between the supply of services to drug users and demand. These complaints, sometimes bolstered by reference to UNODC (2009) statistics, were frequently linked to lack of funding.

3. Funding

An obvious connection exists between insufficient organizational capacity and insufficient financial support. Most of those who noted the former also noted the latter and connected them.

4. Professional training

Closely linked to insufficient organizational capacity and funding is the limited professional training that many harm reduction and treatment staff have had and have access to. Participants commented that lack of professional training limits the scope and quality of services that organizations can provide. At least two participants (a police officer and a doctor) stressed that for RTI to be successful, it would need to be implemented by people with appropriate professional training. As in other developing countries (Dickson-Gómez 2012), professional training in working with drug users appears to be limited in Afghanistan and is one arena where international assistance could be provided.

Physical and Economic Risk Environment

1. Poverty

The majority of participants acknowledged the extreme poverty that drug users endure, and many cited it as a barrier to harm reduction and treatment services, as well as a cause of problem drug use. As one social worker explained, addicts “started narcotics because of poverty.” “They were very poor; a job was not available for them. To get relieved, they started to get high . . . then they started heroin.” Lack of shelter and the inability to afford transportation are the markers of poverty that participants most often referred to. These, among other unmet basic needs, are also what Todd et al. (2009b) found to be IDUs’ most pressing problems. Other markers of extreme drug user poverty that participants noted include susceptibility to being recruited for suicide attacks (to earn money for families) and the selling of harm reduction items.

2. No sanctioned space for drug use

Given the stigma associated with drug use, the harassment of drug users by the police and community, drug users’ consequent need to conceal their drug use, and the difficulty of concealing smoking, participants recommended establishing socially sanctioned spaces for this

form of drug consumption. Justifications for such a space ranged from protecting non-users (particularly children) from second-hand smoke to protecting drug users from harassment and persecution and thus facilitating their access to services and enabling them to actually implement practices that reduce harm.

For example, an NGO project manager reported that “not having a distinct place for the drug users so that they could all use drug[s] in that place” hinders implementation of and access to services for drug users. “Providing a place for them to use drugs is a very good service that we can propose for them,” he continued. “If the place is distinct,” asked the interviewer, “there every kind of service could be provided?” “The centers can provide them services,” he replied. “This way also the addicts could have access to the services provided to them.” Focus group members reiterated this view.

Social worker (SW) 1: In my opinion, from now if we confess it or not, there are drugs in our country and drug users. The government also knows this and all the world also knows this. We have the highest number of drug users in the world. The government should designate a place for them, so that the centers which provide help for them should go and give them services there, and they also come there and use their drugs there, use their drugs there. In my opinion, it would make the level of injection very low.

SW2: [interrupting] It would make it lower.

SW1: It would make it lower because in provinces and districts there was once the injectors very much the level of HIV was also very high, and one month ago when I went there the level of injectors come to 1 percent [i.e., IDUs are 1% of drug users] because they had a place of using drug. They would come there and would consume their drugs there. We had counseling with them; we talked with them about the harms of injection; it made the level of injection to one percent.

Q: In your opinion, one thing that persuades them to come from injection to smoking, it is that we provide them facilities that we should save them from the police and people chasing them away?

SW2: Yes.

Doctor: Provide them with safe place.

SW3: They should have a place, a time, they would smoke; they won't inject.

In short, many participants believe that not having a sanctioned space to use drugs presents a significant barrier to services, especially a smoking RTI. Effective implementation of a smoking RTI may therefore also require provision of such a space in addition to the standard counseling, foil, and matches. Precedent for such “tolerance areas” exists (Riley and O’Hare 2000). For example, they have taken the form of drug consumption rooms or supervised/safe injecting rooms in Europe, Australia, and Canada (Haemmig and van Beek 2005; Hedrich et al. 2010), as well as unmolested open-drug-scene parks in Frankfurt, Germany, in the 1980s that facilitated provision of services to heavy drug users (Riley and O’Hare 2000). But not all tolerance areas have been a success. “Needle Park” in Zurich, Switzerland, for example, was closed twice in the early and mid 1990s because it became “unmanageable” (Riley and O’Hare 2000). Nevertheless, the successes demonstrate that the concept is viable. And if one considers how the ruined Russian Cultural Center in Kabul once functioned as a kind of tolerance zone before drug users were evicted from it in 2010 (Redmond 2013), one could perhaps argue that precedent for at least a very limited form of de facto sanctioned drug use space exists in Kabul as well. In the case of Kabul, what appears to be needed, however, is not so much an open-air tolerance zone as an enclosed space where smoking can occur and services can be delivered, including the option of treatment for those who desire it.

3. Lack of security

Several participants indicated that lack of security presents a barrier to harm reduction and treatment services. This applies to Kabul, but especially to areas outside the city. For example, a social worker suggested that service providers could use protection by government security officers both at their centers and out in the field. “No one has guaranteed our security,”

she said. A doctor explained that although areas outside Kabul need services for drug users, “they are not secure, and personnel with a low salary do not go to work there. Like Maidan Shar Wardak and Logar provinces; there is war and no one could go there from Kabul to work.” Another doctor summed up the situation thus: “We can tell you that it [provision of harm reduction services] can only be inside the Kabul city. The surroundings, for example, some districts have security problems where personnel can’t be sent.”

But lack of security doesn’t just impede service providers; it impedes potential service users as well.

Besides this [distance and terrain] there are many other problems, like financial and security problems, that they [addicts] can’t reach to harm reduction services. . . . [I]n Afghanistan we have security problems in general, so the addicts can’t easily come to centers to take the packages and become aware of those harms, so, itself is a problem. [social worker, KI 14]

These “security problems” persist into the present. In fact, 2014 was the “bloodiest”¹⁶ since the war began in 2001 (Rasmussen 2014).

Route of Drug Administration

1. Drivers of injecting

Supporting Todd et al.’s (2009b) findings among IDUs, participants claimed that injecting is more desirable than smoking because of its potential to conceal drug use (e.g., from harassing police), more pleasurable and longer-lasting effects, greater ease of administration, and greater efficiency (i.e., enhanced per-unit effect). Likewise, they also noted the potential for programs to encourage injecting by providing more services to injectors than to non-injectors (Todd et al. 2009b). All of these are potential barriers to an RTI.

It is worth observing that the barrier to RTI posed by the justifiably desirable concealment that injecting affords has an additional dimension. Concealment could also be a

¹⁶ As measured by the number of Afghan military and civilian deaths.

barrier to RTI to the degree that it leads the public to think that RTI increases drug use. That is, if all the relatively concealed current injecting suddenly turned into easily detected smoking, communities might inaccurately (but understandably) perceive that RTI worsens the problem that it purports to address. A social worker signaled this possibility:

[T]he people would first think of it [RTI] negatively and would say that the number of addicts increased. But in fact the number of addicts are very high. Since they inject and the people don't see them. They inject it immediately, while in smoking, it takes some time. The people see them. If this information is given before to the people, the society, and the centers, that we have such a program and say to them that injection has this kind of harms and the benefits of smoking are these that we can reduce the amount of drug on them daily They won't be obstacle. Instead, they would help the centers.

This potential problem that she points to intersects with previously discussed barriers, namely, lack of knowledge and the consequent opposition that can result from it.

2. Difficulty of the smoking technique

To the degree that smoking is difficult to learn, as a few participants indicated, the smoking technique itself is a barrier to RTI. For example, a doctor in the focus group explained that “the ones who first are smokers and then injectors . . . can do [it, i.e., smoke] easily.” But

the ones who directly started injection, they don't know the meaning of smoking, like it's difficult for him. There are patients who are directly IDUs. The ones who first are smokers and then become IDU, they can do it; and the ones who are directly IDUs, it is difficult for them.

Benefits of RTI

As with barriers, participants discussed many standard, well-documented benefits (e.g., disease prevention) that apply equally to harm reduction, RTI, and treatment, whether or not they explicitly linked them to all three intervention dimensions. The majority, however, did link prevention of disease, wounds, and overdose to harm reduction and RTI. This is an important finding because it demonstrates familiarity with harm reduction theory and practice among at least a small subset of service providers and other stakeholders in Kabul. But rather than rehearse

these well-known benefits and discuss this second primary theme in general, as I did with barriers, I limit the following discussion to three benefits that are particularly relevant to implementing an RTI program. Despite this focus on RTI, however, treatment remains a commonly mentioned topic among participants, reflecting its overall salience in the data.

1. Facilitates treatment

Almost all participants noted that smoking facilitates treatment or that an RTI would. Many, in fact, emphasized this as one of RTI's benefits. The following comments of a doctor illustrate the theme best, as well as the general notion of tapering drug consumption to achieve abstinence that pervades the data.

There are a lot of benefits [of an RTI]. It is very difficult to directly start treatment on injectors. When they are once changed to smoking, then we can step by step decrease their drug amount and then make them ready for treatment and make them quit it. . . . This program definitely has benefits because if we could change them from injection to smoking, we can easily start treatment on them. . . . It is easier to cure the smokers. The patients who inject or use any kind of injection, they are very difficult to cure as compared to the treatment of the smokers. . . . When they come here, their detoxification stage is very long. It takes them more time, the difficulties they face in the detoxification process, and the pains and other complications in this process. And they face more difficulties in quitting drugs as compared to smoking addicts.

Given the dominance of abstinence-based treatment approaches, as already discussed and which this theme further supports, an RTI's potential to facilitate treatment could prove particularly effective in persuading stakeholders to adopt it or permit its implementation. In fact, when combined with the potential to immediately reduce HIV risk (by reducing injecting), the potential to facilitate treatment makes for a compelling argument in favor of RTI. Moreover, the combination of these potentials illustrates how "abstentionism" can be compatible with harm reduction, even if the latter does not prioritize the reduction of drug use (Riley and O'Hare 2000).

2. Improves social standing of IDUs

The majority of participants claimed that one of the benefits of harm reduction, RTI, and treatment is that they can improve drug users' standing (status, character, etc.) in the eyes of their family and society more broadly. For example, smokers are deemed to be more functional than IDUs.

A: As it is noticed in the society, the injected addicts are mostly being chased away from their home as compared to smoking addicts. In spite of being addicts, the smokers can still be beneficial to their family and children but the injecting patients are not. . . . Smoking patients come and take their narcotic drug and counseling then they go after a work. But in contrast, the injected patients are day and night thinking of how to find drug and inject. Even if they find drug six or seven times a day, they will inject. But the smoking patients use only once a day, in the morning or evening and after their work.

Q: So it means that the smoking patients are more stable? They can work for the society and are more accepted than the injectors?

A: As we have seen in the society, it's like that. [NGO project supervisor]

Transitioning to smoking would thus appear to hold out the promise of reducing stigma.

3. Incentivizes smoking over injecting

This is essentially the converse of the unintentional incentivization of injecting already referred to (drivers of injection) whereby focusing services on injectors to the near exclusion of smokers potentially encourages injecting over smoking. Approximately half of the participants argued that a benefit of RTI is that it would incentivize smoking over injecting by providing material incentives to smoke and by preventing agencies from excluding smokers from services. It would also eliminate barriers (lack of foil and matches, but not necessarily lack of sanctioned smoking space) to continuing to smoke or transitioning to smoking. As one doctor said:

The big benefit of it [RTI] would be that up to now that I have seen in Kabul and I am acquainted with the centers, they focus a lot on the injectors. They are given every kind of services, and the injecting patients are given beds in the winter and they made a dormitory and everything is made for them, but there isn't any specific attention to the smoking patients. If there is more attention to the smoking patients, the injection patients

would be compelled that they come from injection to smoking because there would be more facilities for smoking so that their treatment would be easy.

A social worker in the focus group said much the same and claimed to have actually observed the incentivization of injecting.

In my opinion, it is possible that it [RTI] would attract more, it would persuade them more to come, because that up to now, for example, I won't take its name. It was an NGO which distributed biscuits to injectors, and the ones who were smokers, there wasn't any services to them. We witnessed that lots of them come from smoking to injection, so that they could also get these services.

Concerns about incentivizing injecting are well-founded, for Todd et al. (2009b:116) report that IDUs themselves stated that one reason for switching from smoking to injecting is “that IDUs get help from organisations (jackets, soap, shoes) and journalists pay for pictures of IDUs injecting where non-IDUs do not receive these advantages.” Moreover:

The economic realities associated with less drug needed each day with injecting may compel current smokers to change in this impoverished environment. These factors should be considered when implementing policy as preventing initiation of injecting is one means of harm reduction; this concept . . . needs to be emphasized as the official policy to groups planning to implement harm reduction This is particularly important as harm reduction programmes are seen by some IDU[s] to provide better or more services to injectors and may unwittingly encourage initiation of injecting. Though few IDU[s] remarked on this bias as a reason to start injecting, harm reduction service providers and the government bodies providing oversight must ensure that there is no bias towards injectors in services received. [Todd et al. 2009b:118]

CONCLUSION

The suffering and hardship that decades of imperial war and geopolitical rivalry have accomplished in Afghanistan can in no way be adequately addressed by merely implementing an RTI. One does not show up to a burning house with a glass of water to put the fire out—unless, of course, one is deluded or a glass of water is all one has. I hope that I am not deluded, and an RTI is not all that “we” (i.e., the rich nations of the capitalist core) have, as evidenced by the massive sums of military spending described above. To reiterate: ample resources exist to meet

the enormous unmet accomplished need in Afghanistan, not the least of which pertains to drug use and HIV, but the political will and proper balance of power do not. “It is not that ‘we’ are broke or that we lack options,” as Naomi Klein (2014) says in reference to responding effectively to climate change, a comment that applies as well to problem drug use. Nevertheless, there are real, objective constraints on the kinds and scale of HIV interventions that are currently possible in Kabul and Afghanistan more generally. Illuminating some of those constraints and the structural factors at the root of problem drug use and HIV infection in Afghanistan, as I have tried to do here, is intended to contribute to the larger, longer-term task of developing responses and interventions that are commensurate with the scale of suffering and need. Meanwhile, immediate needs must be addressed creatively and pragmatically with the resources at hand. Toward that end, I summarize this study’s findings and make explicit some of their implications.

First, RTI is feasible and poses no harm. The majority of participants stated that RTI could be implemented in Kabul and that it would cause no harm. Its effects would be entirely positive, they claimed. To the degree that they are knowledgeable, adequately positioned to make such an assessment, and wield some degree of policy-influencing power, it would seem that RTI is feasible and desirable. At the least, with effective education and promotion, stakeholders and gatekeepers would appear to be potential supporters of and not barriers to RTI. Therefore, it appears to be a viable concept worth pursuing further. However, it is worth noting that while a ministerial doctor appears to view harm reduction as enabling, he is an outlier among participants in his views on harm reduction. Because of his institutional position, however, his views could have a formidable impact. That is, to the degree that they are representative of those occupying influential ministerial positions, they could pose a significant barrier to implementing RTI in Kabul.

Second, RTI would, according to participants, facilitate treatment. Given the dominance of abstinence-based approaches to treatment, a particularly persuasive argument for RTI might be to emphasize its potential (beyond preventing disease, overdose, etc.) to facilitate treatment, as so many participants do, and to point out that programs are already encouraging injectors to smoke. One objection to this, however, might be that harm reduction (and by extension RTI) is not about reducing drug consumption or promoting treatment, which is true. But in a situation where abstinence-based treatment dominates, OST is not feasible, and an HIV epidemic is emerging, it may be prudent to promote a harm reduction measure for its potential to facilitate treatment and thereby increase the chances of its uptake. Such a potential transgression of harm reduction tenets may be warranted in the case of Afghanistan. After all, pragmatism—if such apparent transgression of principles may be called that—is a central tenet of harm reduction. And, as Riley and O’Hare (2000) argue, harm reduction and abstentionism, while certainly not the same thing, are nevertheless not incompatible. Indeed, harm reduction programs exist that include a treatment-referral component (Singer et al. 1995).

Third, the positive view of methadone expressed by many participants in the face of the MCN’s opposition to it recommends cautious optimism regarding the practical implications of participants’ positive views of and support for RTI and statements affirming its feasibility. All stakeholders—including drug users themselves¹⁷—must support (in practice and not just rhetorically) a harm reduction program for it to be effective. If drug users do not see it as beneficial, then they have no reason to participate in it. If police and communities do not support it, they can and may severely limit its effectiveness. If government or other influential institutions do not support it, then the program may never even get effectively off the ground—

¹⁷ The Client Component of the study suggests that drug users in Kabul would support an RTI (Santelices n. d.).

no matter how much scientific evidence and practitioner support for it exists (Pisani 2010; Singer et al. 2005). The MCN's repeated obstruction, then, of OST implementation in complete opposition to the MoPH and WHO support for it should inform all practical inferences from participants' support for RTI and positive assessment of its feasibility.

Fourth, a sanctioned place to smoke may be necessary for RTI to be effective. In light of the stress that many participants place on providing a socially sanctioned space for drug use and the detrimental effects of police and community harassment, it may be worthwhile to consider including the provision of a smoking space in a potential RTI program. Without such a component, offering foil, matches, and encouragement to smoke could prove ineffective. Forms of tolerance areas have operated and currently operate as effective HIV prevention measures in other parts of the world. Arguably, precedent for some degree of such a tolerance area exists in Kabul in the form of the ruined Russian Cultural Center before drug users were evicted from it in 2010.

Fifth, fostering cooperation and disseminating knowledge would be key to an RTI's success. That participants emphasize that an RTI program cannot be successful without broad-based cooperation and support from the community and police, without informing them of the benefits of harm reduction and RTI, and without involving them in planning means that these issues should be at the forefront of planning for and implementing an RTI. As Stanekzai et al. (2012) argue, gaining community support for harm reduction is critical for effectively addressing the spread of HIV among IDUs. Increased advertising about harm reduction services and the harms of drug use through various media—a need which several participants stressed—might significantly aid this process. It would certainly benefit drug users and perhaps reduce stigma.

Sixth, extensive, effective RTI programming would require a significant increase in funding and organizational capacity. Given the insufficient funding and organizational capacity that participants report (and research [e.g., Mercille 2013] and government reports [e.g., MCN 2013] confirm), incorporating an RTI program into already strained organizations would require robust, stable funding and material supports.

Finally, the insights gained from participants underscores the value of qualitative methods not just for program evaluation (Singer et al. 1995), but also for feasibility assessment. We still have much to learn about preventing an explosive HIV epidemic under challenging circumstances, but it is clear that qualitative research offers an important tool in the ongoing effort to limit the spread of infectious disease in a world that continues to struggle with both old and new infectious threats to human health and well-being.

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